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Lori Bielinski, Executive Director
Washington State Chiropractic Association
21400 International Blvd. Suite 207
SeaTac, Washington 98198

Dear Lori,

As requested, I have reviewed the Regence BlueShield Chiropractic Agreement (rbsclagdc7) effective January 1, 2008. For the most part, this contract represents a vast improvement from past provider agreements both because the drafting of a higher quality and because issues once vague have been clarified. Below you find an explanation of key contract elements.

I. *Definitions*

"**Medically Necessary**" is defined solely for the purposes of benefit determination. The definition is limited for the purpose of determining what services are reimbursable and has no bearing on what services may be available or provided by the chiropractor. This is a significant departure from standard medical necessity definitions. The definition was probably intended to limit Regence liability exposure and permit the company greater latitude in defining for itself what will be "medically necessary" for payment purposes. This change avoids the problem chiropractors have had in the past when an insurer labels a service and medically unnecessary thereby implying more than the fact that the insurer won't pay for the service. With the change, no "stigma" is attached to the determination other than a statement that the company does believe the service is one that meets the company's standards for payment.

One problem with the definition of "medical necessary" is that a disagreement between the chiropractor and the company may be contested in the provider appeals process. This sets up two different processes. If a consumer disputes medical necessity, the dispute is a "grievance" subject to state regulations governing "grievances" and includes access to outside independent review. This difference presents some potential for issues where outcomes relating to medical necessity disputes may vary depending upon whether the dispute is provider or consumer initiated.

"**Patient**" is defined as a person entitled to benefits under a Subscriber Agreement, as the subscriber or enrolled dependent. This definition confuses two separate classes of persons – those who have a relationship with the practitioner and those who have a relationship with the Company and combines them. This creates problems with traditional usage of the word patient.

"**Participating Provider**" and "**Participating Provider Network**" and "**Provider Network**" are a series of definitions intended to describe the chiropractor's relationship to the company. The definitions are internally inconsistent and in particular, the “Participating Provider” definition creates opportunities for mischief by the company.

- Participating provider is defined unlike any other previous similar definition in that the definition uses conditional language rather than merely describe the contractual relationship between the parties. Typically, “participating provider” is defined by noting that the provider is one who is under contract and appointed to a network. The Regence definition adds: “legally qualified to provide the service” and “eligible for reimbursement under a Subscriber Agreement.” Thus, a chiropractor can be under contract with Regence, appointed to a network, qualified by law to provide the service but not “eligible for reimbursement” (whatever that means) thereby rendering the provider “non-participating.” The use of this conditioning language may present problems for both sides since the provider can argue that he or she is not participating and therefore owes no discount while seeking payment from a patient who has been advised that the provider is a “participating provider.”
- “Participating Provider Network” is purportedly the generic version of the definition of “Provider Network”; in other words, a participating provider network is the collection of facilities and providers while a provider network is the Regence BlueShield provider network. Note that neither “provider” nor “facility” is explicitly defined.

“**Subscriber Agreement**” is defined to include both health plans between the public and Regence and administrative services contracts between Regence and other payors such as an employer’s self-funded health plan. Thus, chiropractors participating in the network could be “participating providers” for a broad range of plans including state and federal plans.

II. *Relationship between Clinic and Company*

This section governs most of the substantive aspects of the relationship between Regence and the provider. Some of these provisions are highlighted below either for emphasis or to point out a problem.

Paragraph 2.2 contains provisions that separate out each of the parties liabilities with respect to patients and includes the required Washington provision that chiropractors may freely advise their patients as to appropriate care irrespective of Regence decisions regarding coverage of the care.

Paragraph 2.4 incorporates the practitioner manual into the contract including billing and medical management requirements. Regence will make these documents available to practitioners; however, practitioners should be aware that Washington law requires Regence to make these documents available for review prior to contracting as well as after contracting. [WAC 284-43-320(4)] Providers should make sure in advance to review this manual to assure that contract compliance is both possible and desirable. Changes to the manual will be made with 60 days notice to providers. The contract will trump the manual in the event of any conflict.

Paragraph 2.7 throws in the "kitchen sink" for incorporation by reference in the contract. Practitioners agree to provide services "in accordance with the…subscriber agreement, this Agreement, the Practitioner Manual, other Company directives and the rules, procedures and policies established by the Company, and with the usual professional standard of care and medical and billing practices accepted by the appropriate medical community." This permits Regence to argue breach of contract for a variety of reasons limited only by the Company's labeling of a behavior as not in conformance with company policies and with practices accepted by the profession. It would be advisable to request all such documents, policies and procedures when signing the contract to ensure that full disclosure is made by the Company.

Paragraph 2.8 highlights a critical component of a practitioner's daily practice with respect to insurance reimbursement. Here the practitioner agrees not to hold Regence responsible for either a representation by the patient that he or she has coverage or a representation by Regence that coverage exists UNLESS "the Company has provided prior authorization to the Clinic for a requested service." Therefore, verification of coverage requests should be in the form of a prior authorization to avoid late problems when the Company makes a mistake. This statement in the contract stems from a Washington requirement that prohibits a plan from retroactively denying coverage for "care that had prior authorization under the plan's written policies at the time the care was rendered…" [WAC 284-43-410(3) (h)] Essentially, this contract provision is saying that any confirmation of coverage by the Company is not binding unless the confirmation constitutes a "prior authorization" whatever that may be.

Similarly, paragraph 2.9 states that the Company is not liable for payment to doctors when the Company retroactively terminates a patient's coverage UNLESS the Company issued a "prior authorization." Tacked onto this paragraph (almost as an afterthought given its placement in the contract) is the additional statement that practitioners agree to abide by and participate in the Company's Medical Management program including those requirements established in any other "Company communications or publications." Presumably, the failure to read a bulletin or Email could result in practitioner failure to follow a standard and thereby in a violation of the contract.

Paragraph 2.10 governs medical records. Practitioners agree to maintain records "in accordance with Company's requirements" in addition to the usual state and federal law standards. Practitioners should carefully review Company record keeping standards to avoid late problems and requests for refunds by the Company. These records must be kept for 10 years.

Paragraph 2.11, in part, provides that Company access to medical records is free except for utilization review which is governed by the duplication rates in the practitioner manual.

Paragraph 2.12 sets forth comprehensive provisions governing Company audits of provider records. These should be carefully reviewed by providers. Among the significant provisions of this paragraph are detailed record requirements and consequences for deficient records which may include future reduction in compensation, requests for refunds and termination.

Paragraph 2.13 provides an odd exception to the standards governing health information under HIPAA. Practitioners are required to obtain "written authorization" from patients prior to submitting claims on behalf of such patients.

Paragraph 2.14 provides the "death penalty" for violation of any contract provision governing billing or charging patients. The Company may immediately terminate the contract and deny in whole or part, any claim related to the inappropriate billing of the patient.

Paragraph 2.15 lists various credentialing requirements for clinic participation in the Regence network. Among these critical standards are provisions noting that only those chiropractors listed in Exhibit A may be reimbursed for care to Regence enrollees. Neither the Company nor contracted providers may "bad-mouth" each other to patients.

Paragraph 2.18 prohibits the disclosure of reimbursement rates under the contract.

III. *Compensation and Billing*

Paragraph 3.1 permits the Company to change reimbursement rates with 60 days notice to practitioner. Once a practitioner accepts a payment at the new rate, the practitioner is deemed to have accepted the new rate.

Paragraph 3.2 requires a clinic to bill the Company at the usual and customary rate. Clinic may not "bill services provided to Patients with health care coverage at a rate higher than the Clinic bills services provided to Patients without health care coverage."

Embedded in 3.2 are additional record-keeping standards. In particular, these standards include the following:

> "Any alterations or amendments to these contemporaneous records must include the date and time of the alteration or amendment, be signed by the person making the alteration or amendment, refrain from obliterating or obscuring any prior documentation and be clearly identified and identifiable as an amendment or alteration. The Company may deny claims in those cases, where ***in the Company's sole discretion***, there is inadequate documentation of the services rendered, in which case the Clinic shall not bill the Patient."

Paragraph 3.3 prohibits a practitioner from waiving or otherwise failing to collect deductibles and other coinsurance except in isolated instances for charitable purposes.

Paragraph 3.4 sets forth a very specific standard for obtaining patient consent prior to billing for non-covered services. This written notice signed prior to service must include patient name, specific service, date of service, cost of service, and reason why the service is not a covered service.

IV. *Administration*

Paragraph 4.3 appears to require practitioners to accept the "negotiated" contract rate for all services provided to "subscribers." This provision is ambiguous and therefore subject to uncertain interpretation. For example, "subscriber" is an undefined term. The Agreement generally uses the word "patient" as the person entitled to benefits under a subscriber agreement and indirectly refers to the patient as the subscriber [see above]. Thus, a practitioner may or may not have to charge a negotiated discount from usual and customary rates depending upon whether in a given circumstance the person is a "subscriber." The exact language of the provision follows:

> "The Clinic agrees to accept the negotiated amount as payment in full, whether that amount is paid in whole or in part by the subscriber and/or enrolled dependent, or by the Company, or by any combination of payors, including other payors which may pay before the Company in the order of benefit determination."

Practitioners should obtain clarification of the amount that may be billed and collected under various scenarios involving other payors in dual coverage and non-coverage circumstances.

V. Member Hold Harmless

Section V contains the statutorily required "hold harmless" provisions that prohibit practitioners from collecting funds from a patient when such fund are owed by the health insurance company under contract with the practitioner.

VI. Dispute Resolution

Comprehensive standards govern various disputes between practitioners and Regence. These provisions are also set forth in Exhibit D. The most critical provision in this section is the one governing the timeline for appeal of Company decisions. If a dispute is not raised within the proper timeframe, then the dispute is waived. Generally, the default time period is 30 days unless otherwise stated in the Agreement. Nevertheless, in keeping with state law requirements, nothing in the Agreement prevents a chiropractor from pursuing judicial remedies.

VII. Term and Termination

The Agreement continues until terminated with 60 days notice except in limited circumstances such as license revocation in which case termination may be immediate. Termination for cause is subject to the dispute resolution process.

VIII. Miscellaneous Provisions

The Agreement may be amended in various ways. First, by consent of each party; second, with 60 days notice; third, immediately as requires by law change; and finally, indirectly through amendment of the practitioner manual with 60 days notice. Again, practitioners should familiarize themselves with these other documents since these documents are incorporated into the Agreement by reference.

If you have any questions, contact me at 253-759-7767.

Best regards,

John S. Conniff